

APPLICATION FOR WIDOW'S OR WIDOWER'S INSURANCE BENEFITS*

(Do not write in this space)

I apply for all insurance benefits for which I am eligible under Title II (Federal Old-Age, Survivors, and Disability Insurance) and Part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act, as presently amended. The information you furnish on this application will ordinarily be sufficient for a determination on the lump-sum death payment.

*This may also be considered an application for survivors benefits under the Railroad Retirement Act and for Veterans Administration payments under title 38 U.S.C., Veterans Benefits, Chapter 13 (which is, as such, an application for other types of death benefits under title 38).

If you were receiving benefits as a wife/husband at the time of your spouse's death, you need complete only the circled items. All other claimants must complete the entire form.

①	(a) PRINT name of deceased wage earner or self-employed person (<i>herein referred to as the "deceased"</i>)	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Check (X) one for the deceased	<input type="checkbox"/> Male <input type="checkbox"/> Female
	(c) Enter deceased's Social Security Number	_____
②	(a) PRINT your name	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Enter your Social Security Number	_____
	(c) Enter your name at birth if different from item 2(a)	FIRST NAME, MIDDLE INITIAL, LAST NAME

PART I -- INFORMATION ABOUT THE DECEASED

3.	Enter date of birth of deceased	MONTH, DAY, YEAR
④	(a) Enter date of death	MONTH, DAY, YEAR
	(b) Enter place of death	CITY AND STATE
⑤	Enter name of the State or foreign country where the deceased had a fixed, permanent home at the time of death.	
6.	(a) Did the deceased ever file an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? <i>If unknown, check this block</i> <input type="checkbox"/>	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) and (c).)</i> <input type="checkbox"/> No <i>(If "No," go on to item 7.)</i>
	(b) Enter name(s) of person(s) on whose Social Security record(s) other application was filed.	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(c) Enter Social Security Number(s) of persons named in (b). <i>If unknown, check this block</i> <input type="checkbox"/>	_____

ANSWER ITEM 7 ONLY IF THE DECEASED DIED PRIOR TO AGE 66 AND WITHIN THE PAST 4 MONTHS.

⑦	(a) Was the deceased unable to work because of illnesses, injuries or conditions at the time of death?	<input type="checkbox"/> Yes <i>(If "Yes," answer (b).)</i> <input type="checkbox"/> No <i>(If "No," go on to item 8.)</i>
	(b) Enter the date the deceased became unable to work.	MONTH, DAY, YEAR
8.	(a) Was the deceased in the active military or naval service (including Reserve or National Guard <i>active</i> duty or active duty for training) after September 7, 1939 and before 1968?	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) and (c).)</i> <input type="checkbox"/> No <i>(If "No," go on to item 9.)</i>
	(b) Enter dates of service.	FROM: (Month, year) TO: (Month, year)
	(c) Has anyone (including the deceased) received, or does anyone expect to receive, a benefit from any other Federal agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No

ANSWER ITEM 9 ONLY IF DEATH OCCURRED WITHIN THE LAST 2 YEARS.

9.	(a) About how much did the deceased earn from employment and self-employment during the year of death? _____	Amount \$
	(b) About how much did the deceased earn the year before death? _____	Amount \$
10	(a) Did the deceased have wages or self-employment income covered under Social Security in all years from 1978 through last year? _____	<input type="checkbox"/> Yes <i>(If "Yes," skip to item 11.)</i> <input type="checkbox"/> No <i>(If "No," answer (b).)</i>
	(b) List the years from 1978 through last year in which the deceased did not have wages or self-employment income covered under Social Security. _____	

11. CHECK IF APPLICABLE:

☐ I am not submitting evidence of the deceased's earnings that are not yet on his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in my benefits will be paid with full retroactivity.

12. Enter below the information requested about each marriage of the deceased, including the marriage to you.

To whom married		When (Month, Day, and Year)	Where (Enter name of City and State)
Last marriage of the deceased	How marriage ended	When (Month, Day, and Year)	Where (Enter name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) _____		
To whom married		When (Month, Day, and Year)	Where (Enter name of City and State)
Previous marriage of the deceased (IF NONE WRITE "NONE")	How marriage ended	When (Month, Day, and Year)	Where (Enter name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) _____		

USE "REMARKS" SPACE ON BACK PAGE FOR INFORMATION ABOUT ANY OTHER PREVIOUS MARRIAGE

13	Is there a surviving parent (or parents) who was receiving support from the deceased at the time of death or at the time the deceased became disabled under Social Security Law? _____	<input type="checkbox"/> Yes <i>(If "Yes," enter the name and address in "Remarks.")</i> <input type="checkbox"/> No
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PART II -- INFORMATION ABOUT YOURSELF

14.	(a) Enter name of State or foreign country where you were born. _____	
If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 15.		
	(b) Was a public record of your birth made before age 5? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	(c) Was a religious record of your birth made before age 5? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

- 15 Enter below information about each of your marriages. Indicate your marriage to the deceased by entering deceased's name (if you are applying for widower's benefits, enter the maiden name of the deceased); it is not necessary to repeat other information about this marriage you have already given in item 12. Enter complete information on all other marriages, whether before or after you married the deceased.

To whom married		When (Month, Day, and Year)	Where (Enter name of City and State)
Your current or last marriage	How marriage ended	When (Month, Day, and Year)	Where (Enter name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) _____		

To whom married		When (Month, Day, and Year)	Where (Enter name of City and State)
Your previous marriage (IF NONE WRITE "NONE")	How marriage ended	When (Month, Day, and Year)	Where (Enter name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) _____		

USE "REMARKS" SPACE FOR INFORMATION ABOUT ANY OTHER MARRIAGE

IF YOU ARE APPLYING FOR SURVIVING DIVORCED SPOUSE'S BENEFITS, OMIT 16 AND GO ON TO ITEM 17.

16	(a) Were you and the deceased living together at the same address when the deceased died? _____		<input type="checkbox"/> Yes (If "Yes," skip to item 17.)	<input type="checkbox"/> No (If "No," answer (b).)
	(b) If either you or the deceased were away from home (whether or not temporarily) when the deceased died, give the following: Who was away? _____ <input type="checkbox"/> Deceased <input type="checkbox"/> Surviving spouse			
	Date last at home:	Reason absence began:	Reason you were apart at time of death:	
	If separated because of illness, enter nature of illness or disabling condition.			
17.	(a) Have you (or has someone on your behalf) even filed an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? _____		<input type="checkbox"/> Yes (If "Yes," answer (b) and (c).)	<input type="checkbox"/> No (If "No," go on to item 18.)
	(b) Enter name of person on whose Social Security record you filed other application _____			
	(c) Enter Social Security Number of person named in (b). (if unknown, so indicate) _____			

DO NOT ANSWER QUESTION 18 IF YOU ARE AGE 66 OR OLDER. GO ON TO QUESTION 19.

18.	(a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions? _____	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) .)</i>	<input type="checkbox"/> No <i>(If "No," go on to item 19.)</i>
	(b) Enter the date you became unable to work. _____	(Month, day, year)	
19.	Were you in the active military or naval service (including Reserve or National Guard <i>active</i> duty or active duty for training) after September 7, 1939 and before 1968? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20.	Did you or the deceased work in the railroad industry for 7 years or more? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21.	(a) Did you or the deceased have Social Security credits (for example, based on work or residence) under another country's Social Security System? _____	<input type="checkbox"/> Yes <i>(If "Yes," answer (b).)</i>	<input type="checkbox"/> No <i>(If "No," go on to item 22.)</i>
	(b) If "Yes," list the country(ies). _____		
22.	(a) Have you qualified for, or do you expect to qualify for, a pension or annuity (or a lump sum in place of a pension or annuity) based on your own employment and earnings for the Federal Government of the United States, or one of its States or local subdivisions? <i>(Social Security benefits are not government pensions.)</i> _____	<input type="checkbox"/> Yes <i>(If "Yes," check which of the items in item (b) applies to you.)</i>	<input type="checkbox"/> No <i>(If "No," go on to item 23.)</i>
	(b) <input type="checkbox"/> I receive a government pension or annuity. <input type="checkbox"/> I received a lump sum in place of a government pension or annuity. <input type="checkbox"/> I applied for and am awaiting a decision on my pension or lump sum.	<input type="checkbox"/> I have not applied for but I expect to begin receiving my pension or annuity: _____ (Month, year) <i>(If the date is not known, enter "Unknown".)</i>	

I AGREE TO PROMPTLY NOTIFY the Social Security Administration if I begin to receive a government pension or annuity, based on my own earnings, from the Federal government or any State (or any political subdivision thereof), or if my present government pension or annuity amount changes.

MEDICARE INFORMATION

If this claim is approved and you are still entitled to benefits at age 65, you will automatically have hospital insurance protection under Medicare at age 65. If you are not also eligible for automatic enrollment in the Supplementary Medical Insurance Plan, this application may be used for voluntary enrollment.

COMPLETE THIS ITEM ONLY IF YOU ARE WITHIN 3 MONTHS OF AGE 65 OR OLDER

Medical insurance under Medicare helps pay your doctor bills. It also helps pay for a number of other medical items and services not covered under the hospital insurance plan does not apply to most medical expenses incurred outside the United States.

If you sign up for medical insurance, you must pay a premium for each month you have this protection. If you get monthly Social Security, railroad retirement, or civil service benefits, your premium will be deducted from your benefit check. If you get none of these benefits, you will be notified how to pay your premium.

The Federal Government contributes to the cost of your insurance. The amount of your premium and the Government's payment are based on the cost of services covered by medical insurance. The Government also makes additional payments when necessary to meet the full cost of the program. (Currently the Government pays about two-thirds of the cost of this program.) You will get advance notice if there is any change in your premium amount.

If you are entitled to hospital insurance as a result of this application, you will be enrolled for medical insurance automatically unless you indicate below that you do not want this protection. If you decline to enroll now, you can get medical insurance protection later only if you sign up for it during specified enrollment periods. Your protection may then be delayed and you may have to pay a higher premium when you decide to sign up.

The date your medical insurance begins and the amount of the premium you must pay depend on the month you filed this application with the Social Security Administration. Any Social Security office will be glad to explain the rules regarding enrollment to you.

23.	Do you want to enroll in the Medicare Supplementary Medical Insurance Plan? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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ANSWER ITEM 24 ONLY IF THE DECEASED DIED BEFORE THIS YEAR.

24.	(a) How much were your total earnings last year? _____ \$				
	(b) Place an "X" in each block for each month of last year in which you <u>did not earn</u> more than *\$ _____ in wages, and <u>did not perform</u> substantial services in self-employment. These months are exempt months. If no months were exempt months, place an "X" in "NONE." If all months were exempt months, place an "X" in "ALL." *Enter the appropriate monthly limit after reading the instructions, " <u>How Your Earnings Affect Your Benefits.</u> "	NONE		ALL	
Jan.		Feb.	Mar.	Apr.	
May		Jun.	Jul.	Aug.	
Sept.		Oct.	Nov.	Dec.	

25.	(a) How much do you expect your total earnings to be this year? _____ \$				
	(b) Place an "X" in each block for each month of this year in which you <u>did not or will not earn</u> more than *\$ _____ in wages, and <u>did not or will not perform</u> substantial services in self-employment. These months are exempt months. If no months are or will be exempt months, place an "X" in "NONE." If all months are or will be exempt months, place an "X" in "ALL." *Enter the appropriate monthly limit after reading the instructions, " <u>How Your Earnings Affect Your Benefits.</u> "	NONE		ALL	
Jan.		Feb.	Mar.	Apr.	
May		Jun.	Jul.	Aug.	
Sept.		Oct.	Nov.	Dec.	

ANSWER ITEM 26 ONLY IF YOU ARE NOW IN THE LAST 4 MONTHS OF YOUR TAXABLE YEAR (SEPT., OCT., NOV., AND DEC., IF YOUR TAXABLE YEAR IS A CALENDAR YEAR).

26.	(a) How much do you expect to earn next year? _____ \$				
	(b) Place an "X" in each block for each month of next year in which you <u>do not expect to earn</u> more than *\$ _____ in wages, and <u>do not expect to perform</u> substantial services in self-employment. These months will be exempt months. If no months are expected to be exempt months, place an "X" in "NONE." If all months are expected to be exempt months, place an "X" in "ALL." *Enter the appropriate monthly limit after reading the instructions, " <u>How Your Earnings Affect Your Benefits.</u> "	NONE		ALL	
Jan.		Feb.	Mar.	Apr.	
May		Jun.	Jul.	Aug.	
Sept.		Oct.	Nov.	Dec.	

27.	If you use a fiscal year, that is, a taxable year that does not end December 31 (with income tax return due April 15), enter here the month your fiscal year ends. _____	Month
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IF YOU ARE AGE 65 AND 6 MONTHS OR OLDER, GO ON TO PAGE 6. OTHERWISE, PLEASE READ CAREFULLY THE INFORMATION ON PAGE 7 AND ANSWER ONE OF THE FOLLOWING ITEMS.

28.	(a) I want benefits beginning with the earliest possible month that will be the most advantageous. _____ <input type="checkbox"/>
	(b) I am age 65 (or will be age 65 within 4 months) and I want benefits beginning with the earliest possible month that will be the most advantageous, providing that there is no permanent reduction in my ongoing monthly benefits. _____ <input type="checkbox"/>
	(c) I want benefits beginning with _____. I understand that either a higher initial payment or a higher continuing monthly benefit amount may be possible, but I choose not to take it. _____ <input type="checkbox"/>

ANSWER QUESTION 29 ONLY IF YOU ARE NOW AT LEAST AGE 61 YEARS, 8 MONTHS.

29.	Do you wish this application to be considered an application for retirement benefits on your own earnings record? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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I understand that SSA will use the earnings reported to SSA by my employer(s) and my self-employment tax return (if applicable) as the report of earnings required by law, and adjust benefits under the earnings text. I also understand that it is my responsibility to ensure that the information I give SSA concerning my earnings is correct. I also understand that I must furnish additional information as needed when my benefit adjustment is not correct based on the earnings on my record.

Remarriage prior to age 60 may terminate your benefits. There are certain exceptions which are explained in the informational booklet which you will receive. You must report if you remarry even if you believe an exception applies. We will advise you whether additional evidence is needed and how your benefits may be affected.

I AGREE TO PROMPTLY NOTIFY the Social Security Administration if I REMARRY and to PROMPTLY RETURN ANY BENEFIT CHECK I receive for the month I marry, and for any later month.

REMARKS (You may use this space for any explanations. If you need more space, attach a separate sheet.)

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

SIGNATURE OF APPLICANT

Date (Month, day, year)

Signature (First name, middle initial, last name) (Write in ink)

Telephone number(s) at which you may be contacted during the day

SIGN
HERE 

AREA CODE

FOR
OFFICIAL
USE ONLY

Direct Deposit Payment Address (Financial Institution)

Routing Transit Number

C/S

Depositor Account Number

☐ No Account

☐ Direct Deposit Refused

Applicant's Mailing Address (Number and street, Apt. No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)

City and State

ZIP Code

Country (if any) in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in the Signature block.

1. Signature of Witness

2. Signature of Witness

Address (Number and street, City, State and zip Code)

Address (Number and street, City, State and zip Code)

CHANGES TO BE REPORTED AND HOW TO REPORT
FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE
REPAID, AND IN POSSIBLE MONETARY PENALTIES

- ▶ You change your mailing address for checks or residence. To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.
- ▶ You go outside the U.S.A. for 30 consecutive days or longer.
- ▶ Any beneficiary dies or becomes unable to handle benefits.
- ▶ Work Changes -- On your application you told us you expect total earnings for _____ to be \$ _____.

You ☐ (are) ☐ (are not) earning wages of more than \$ _____ a month.

You ☐ (are) ☐ (are not) self-employed rendering substantial services in your trade or business.

(Report AT ONCE if above work pattern changes.)

- ▶ Change of Marital Status - Marriage, divorce, annulment of marriage.
- ▶ You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- ▶ Custody Change - Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, or changes address.
- ▶ You begin to receive a government pension or annuity (from the Federal government or any State or any political subdivision thereof) or present payment changes.

Disability Applicants

1. You return to work (as an employee or self-employed) regardless of amount of earnings.
2. Your condition improves.

HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer.

WHEN A CHANGE OCCURS AFTER YOU RECEIVE A NOTICE OF AWARD, YOU SHOULD REPORT BY CALLING THE APPROPRIATE TELEPHONE NUMBER SHOWN NEAR THE TOP OF PAGE 8.

The law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct. You must furnish additional information as needed when your benefit adjustment is not correct based on the earnings on your record.

FIGURING YOUR ANNUAL EARNINGS

To figure your total yearly earnings, count all gross wages (before deductions) and net earnings from self-employment which you earn during the entire year. This includes earnings both before and after retirement, and applies to all earned income whether or not covered by Social Security.

In figuring your total yearly earnings, however, DO NOT COUNT ANY AMOUNTS EARNED BEGINNING WITH THE MONTH YOU BECOME AGE 70. Count only amounts earned before the month you become AGE 70.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE ANSWERING QUESTION 28.

Benefits may be payable for some months prior to the month in which you file this claim (but not for any month before you reach age 60 (unless you are disabled)) if:

- YOU WILL EARN OVER THE EXEMPT AMOUNT THIS YEAR.

(For the appropriate exempt amount, see "How Your Earnings Affect Your Benefits.")

If your first month of entitlement is prior to age 65, your benefit rate will be reduced. However, if you do not actually receive your full benefit amount for one or more months before age 65 because benefits are withheld due to your earnings, your benefit will be increased at age 65 to give credit for this withholding. Thus, your benefit amount at age 65 will be reduced only if you receive one or more full benefit payments prior to the month you are age 65.

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY WIDOW'S OR WIDOWER'S INSURANCE BENEFITS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A NOTICE OF AWARD	SSA OFFICE	DATE CLAIM RECEIVED
	AFTER YOU RECEIVE A NOTICE OF AWARD		

Your application for Social Security benefits has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect your claim, you--or someone for you--should report the change. The changes to be reported are listed on page 7. Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	DECEASED'S SURNAME IF DIFFERENT FROM CLAIMANT'S	SOCIAL SECURITY CLAIM NUMBER
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Collection and Use of Information From Your Application - Privacy Act/Paperwork Act Notice

The Social Security Administration is authorized to collect the information on this form under sections 202(e), 205(a), and 1872 of the Social Security Act, as amended (42 U.S.C. 402(e), 405(a), and 1395ii)). While it is voluntary, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security Office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage.

Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security Administration, information may be disclosed to another person or to another governmental agency as follows:

1. to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Veterans Administration); and 3. to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security.)

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT STATEMENT AND TIME IT TAKES STATEMENT:

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.